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January 22, 2014

The Honorable Cristal Thomas
Deputy Governor
Thompson Center, Floor 16-100
100 West Randolph
Chicago, IL 60601
Re: Comments on Medicaid 1115 Draft Waiver Application

Dear Deputy Governor Thomas:

On behalf of its more than 200 member hospitals and nearly 50 health systems, the Illinois Hospital Association (IHA) appreciates this opportunity to provide written comments on the draft Medicaid 1115 waiver application released on January 8, 2014. While we are encouraged by the goals articulated in the application, any final position on the final waiver application will depend upon its specific components, especially the financing mechanisms that the state will utilize to achieve its goals.

The timing of the waiver application is well suited to correspond with the transformation that hospitals and health systems are undergoing. Having served their communities in many cases for over 100 years, Illinois' hospitals and health systems know that it takes much more than "traditional" medical care to achieve healthy communities. This is why hospitals today are working closer than ever with a diverse group of providers across the continuum of care and forming integrated delivery systems to allow for enhanced care coordination. The establishment of incentives to help offset the cost of this transformation is a critical waiver component and is likely to be one of the most cost effective waiver investments. Not only are hospitals and health systems the cornerstones of their communities and the state's health care delivery system, they are the key mechanism to integrate various providers into integrated delivery systems (IDS) that provide care across the continuum.

Since the waiver is quite ambitious in its scope, the waiver application would be strengthened to include an executive summary to clearly articulate the overall vision and value proposition for the waiver. We see the waiver as an opportunity to incentivize providers to move from a volume based delivery system to a value based delivery system. Quality improvements and cost savings will occur through enhanced care coordination by integrated delivery systems. Therefore, waiver proposals should be measured against these criteria. In particular the application would be strengthened with a clear articulation of how the various pathways relate to each other such as how the incentives for IDS development relate to the increased support for long term supports and services and how both initiatives will work with public health to create a transformed delivery system. The application would then also include a discussion of how the additional waiver funding will lead to achieving the Triple Aim.

The following are IHA's specific comments and recommendations on the "Pathways" and other issues:

<u>Pathway 1- Transform the Health Care Delivery System</u>
Illinois hospitals and health systems are committed to the type of transformation described in the draft application. **Given the limited funding available, all waiver**

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recommendations should be evaluated in terms of the extent they transform the delivery system and improve care coordination. While the Care Coordination Entities (CCEs) and Accountable Care Entities (ACEs) are specific examples of these transformation efforts, many other hospitals and health systems are also transforming their care delivery systems. The examples provided for technical support for the CCEs and ACEs are a good indication of the state's commitment to their success. Also, the creation of a new Innovation and Transformation Resource Center (ITRC) would be well received and is consistent with the work that the IHA's Institute for Innovations in Care and Quality is already performing with hospitals to improve outcomes through quality improvement activities and learning collaboratives.

Health System Integration and Transformation Performance Program
We strongly support creating a performance incentive pool and in addition to the potential measures listed, we would request that the application emphasize that this is an initial list and the advisory committee would consider these as well as other metrics. In developing the final list of performance measures, it would be helpful for the waiver application to articulate principles for selecting measures that yield the greatest return on the incentive investment. The measures should strive to "count what counts most" and address areas that are within the control of providers being incentivized. Otherwise, the incentives become more of a lottery than a delivery transformation vehicle. Keeping the most impactful list of measures to a minimum is another principle that will improve the possibility that these incentives will drive real delivery reform. The more focused the measures, the more likely the targeted improvement. Also, a definition of the distressed hospital criteria should be developed as well as a rationale for having separate pools based on this distinction. Safety net providers play an important role and this may be one mechanism to assist them in continuing to provide access to vital health services. We look forward to working with you and providing further input on measurement development.

We fully support incentives that involve performance metrics linked to quality care improvement, development of integrated delivery systems, and support for the health information technology/health information exchange (HIT/HIE) infrastructure. Such an incentive pool cannot simply be a nominal funding amount, but must be large enough to provide substantial incentives available to all hospitals and health systems. **It appears that the incentive pool would be funded with CNOM funding and we would like the final application to specifically state this.** We continue to stress that given the uncertainty of the distribution of the incentives and the likely increased financial responsibility to achieve acceptable performance levels, the payments must not be financed by the current or a new tax or assessment on hospitals, but appropriately from new waiver funding.

On page 48, we request clarification on the request to waive the disproportionate share hospital (DSH) payment requirement for payment of incentives to hospitals under the Health System Integration and Transformation Performance Program. If it is the State's intent to reallocate the $5 million in current DSH payments for private hospitals, we would strongly oppose this reallocation. As we have repeatedly stated, any such incentive program should not be financed from a new assessment or from a reallocation of existing hospital payments. **Also, on page 49, should the waiver of 42 CFR 438.60 also apply to the Access Assurance Program, since those payments will be paid directly by the state to hospitals?**

In addition, it is unclear if the performance metrics would include payments for those medical homes that are clinically integrated with an IDS. Having a separate payment for medical homes would reward those that have already invested in delivery system transformation and would incentivize those that are in the process. One option to consider would be linking additional payments to those medical homes within an integrated delivery system that have been certified by a nationally recognized certification process. A primary care medical home that has demonstrated its commitment by becoming certified would be a worthwhile investment. Such an incentive should be available, in addition to payments from managed care organizations or fee-for-service payments from the state. The waiver presents the state with an opportunity to incentivize the care coordination activities of those medical homes that are part of an IDS. We agree with the proposal on page 38 to formalize its health home program for adults with serious mental illnesses, but incentives for health homes should be broader based.

Access Assurance Pool

We appreciate the State's recognition of the challenges presented in providing services to uninsured and low-income communities. We particularly support the efforts aimed at preserving and enhancing the critical financial support that is needed to assure access to care through an access assurance pool. An access assurance pool is a possible mechanism for allowing the state to at least preserve the current level of federal funding financed by the current hospital assessment. As such the application should state that the distribution should be based on unreimbursed costs, not added performance metrics. **On page19, the second to last sentence in the Access Assurance Pool needs clarification that the pool would include certain non-hospital services and that the costs would be calculated according to Medicare cost reporting standards. We recommend that this sentence read as follows: The Access Assurance Program will help to ensure access to care for critical hospital *and certain non-hospital services* provided to the State's most vulnerable populations as the state moves forward with its planned expansion of Medicaid managed care. The eligible unreimbursed costs in the Access Pool will be calculated in accordance with Medicare cost reporting principles consistent with federal Medicaid requirements.**

While the application contains a nursing facility closure and conversion fund, the application should also contain a similar fund for hospital transitions that would provide funding or debt relief for hospitals reducing their inpatient capacity. This would be an effective method to incentivize more hospitals to change their delivery system and increase their outpatient capacity to be more in line with future health care demands. As the health care system shifts more care to the outpatient setting, hospitals may find that their inpatient capacity may exceed future demand, but there are costs involved in reducing that capacity. A hospital transition fund similar to what is proposed for nursing homes would align the state's goals with those hospitals considering a reduction in inpatient capacity. A voluntary program with established criteria would serve as a catalyst and provide funding to support hospitals (and the communities they serve) to thoughtfully consider and develop a strategy to transition to a format that would meet the evolving health needs of the community.

<u>Pathway 2- Build Capacity of the Health Care System for Population Health Management</u>

We agree with the goal of building linkages between public health and health care delivery systems, but we fail to understand how the brief explanation in the draft application would achieve this goal. In particular, the document states that Illinois will create a premium add-

on payment for health plans that agree to use the funds to develop population health interventions in conjunction with newly created Regional Public Health Hubs. It is unclear why health plans would be the only entities to receive payment to develop population health interventions in conjunction with the newly created regional public health hubs. **We request that hospitals also be eligible for such payments and be allowed to shape the activities that would be performed in return for the incentive financing.** Hospitals will play a key role in such activities and in some instances are already working closely with public health departments. Interjecting the health plans in this process would needlessly divert scarce resources away from the providers who are already developing community needs assessments and would be in the best position to work with the regional hubs. The draft application is completely silent on what activities the health plans would perform in return for this additional funding or how they would be held accountable.

The waiver would be an appropriate mechanism for the regional hubs to collaborate with local hospitals to share data obtained through the community needs assessment. Such voluntary collaboration has potential to align efforts to address the highest priority needs within communities. **The health of our communities is an issue that hospitals are uniquely suited to address as a convener of a wide range of providers and social service agencies.** We recognize that the waiver can play an important role in improving population health that will benefit communities throughout the state. As we mentioned in our previous comment letter, there are a number of examples that hold promise such as providing incentives for hospitals to achieve Baby-Friendly designated status as a way to improve children's health through breast-feeding. Steps to achieve designation include recommending breast feeding over formula to pregnant patients and educating women on the proven health benefits.

This section of the application included a statement that the state will invest in evidence-based prevention and wellness strategies and will test payment reforms for wellness programs and integration of public health services. We would be very interested in receiving more details on what payment reforms for wellness programs might be considered and would like to work with you on identifying potential reforms related to this objective. **Funding to support educational initiatives that strengthen the health literacy of individuals and communities as well as access to patient navigators can optimize the use of health and community resources and lower long-term costs.** Also, the waiver should include providing value-added services to incentivize healthy behaviors, e.g., obesity reduction, smoking cessation, and participation in chronic condition management programs and other health and wellness initiatives. We did not see any mention of these types of incentives to change patient behaviors or increase personal responsibility.

Pathway 3- 21st Century Workforce

IHA shares the goal of increasing the number of primary care providers in Illinois, but we are concerned that the GME proposal is overly restrictive in terms of the criteria for receiving funding. The application reports that Illinois physicians' acceptance of new Medicaid patients is below the national average and this is not surprising when Illinois Medicaid spending is well below the national average. There are a number of anecdotal reports of physician access issues for Medicaid patients, whether it is access difficulties with pediatric subspecialists in the Chicago area or psychiatrists in downstate Illinois.

Rate enhancements for practicing in underserved areas or serving underserved populations as part of an integrated delivery system should also be explored as a more immediate way to

increase capacity. **We also support efforts to allow all clinical staff to practice to the full extent of their training.** As only one example, current Illinois law mandates a written collaborative agreement for each Advanced Practice Nurse (APN) that requires a 1:1 oversight relationship with a physician. This requirement subjects each advanced practitioner to negotiate the terms of their respective practice with a physician that may or may not be congruent with the individual's competencies, skill sets or training. In essence, the physician gatekeeping function allows that provider to set the parameters for what the APN may do or not, which includes performing history and physicals, well-baby checks and prescriptive authority. A similar written agreement requirement also exists for our state's Physician Assistants. With a lower number than the national median of non-physician providers, Illinois has the opportunity through the 1115 waiver to explore oversight models that improve economies of scale and promote evidence-based practice by those qualified to work to the top of their licensed capabilities via interdisciplinary teams to deliver primary care services across the continuum. In addition, other practice constraints could be addressed that presently unnecessarily burden processes and potentially delay Medicaid patients' access to services. These include requirements that only physicians can order durable medical equipment, rehabilitation services for occupational and physical therapies, and sign the Illinois "Physician Order Life Sustaining Treatment" (POLST) form, a document intended to move with the patient across care venues. Without removing barriers for other clinical staff to practice in a team based environment, access to care impediments cannot be fully resolved.

Graduate Medical Education

The health care workforce loan repayment programs described in the application hold promise to increasing the workforce serving the Medicaid population. However, we are concerned that the detailed proposal outlined for graduate medical education is based too heavily on holding GME programs accountable for physician practice location choices that are outside the control of the program. Without substantial changes to the funding distribution, we are concerned that the additional burdens imposed by the program would exceed any potential gain and jeopardize the success of the program. While we appreciate that the physician specialties eligible for this program have been expanded, we still would recommend that emergency medicine be added to the list of eligible specialties. Just recently, studies have reported that increased Medicaid coverage has led to increased utilization of the hospital emergency department. To help accommodate such a demand, it would be wise to include the specialty of emergency medicine in the list of specialties eligible for these GME incentives.

We also appreciate that the incentive program will be structured so that the sponsoring academic institution that sponsors the accredited residency program is the organization that receives the incentive funding. **It is very important that the sponsoring institution is the entity that determines how to participate in this program since it is this institution that obtains accreditation and is in the best position to select the most suitable site for training that meets the criteria of the incentive program.** Allowing the state to also designate health shortage areas will provide increased flexibility so that residency programs throughout the state may be eligible to participate. We appreciate that one of the program criteria is based on percentage of underserved patients, and not on the physical location of the training site. Such flexibility will help to ensure that sponsoring institutions are able to choose the medical home training sites best suited to train resident physicians.

Pathway 4- LTSS Infrastructure, Choice, and Coordination

The focus on needed integration of behavioral and physical health is a high priority for IHA and we are pleased to see it incorporated prominently into the application. For individuals with both serious behavioral health needs and chronic medical conditions, the value proposition of integrated delivery is even greater. IHA supports integrated care and views the patient centered health home as an appropriate model within which to organize and deliver integrated care. **We believe that the health home proposal for persons with serious mental and other chronic illnesses, using primary care providers or behavioral health providers as the health home holds great promise.** Regardless of the site, success of the various health home models will be driven by using multi-disciplinary, team-based staff, evidence-based tools and protocols, care coordination, patient tracking and outcomes measurement, ideally using electronic systems, and adequate financing.

The waiver supports the emergency services pilot at the University of Illinois Medical Center (UIC) in which services are delivered by an interdisciplinary team. This model focuses on addressing the multiple and complex needs of the patient, and the team is able to facilitate access to social and other support services. This pilot, which we strongly support, is the type of pilot that should be supported throughout the state. Although we recognize the health home should eventually reduce reliance on the ED by persons with behavioral health conditions, these programs will be phased in over the next few years and many Medicaid recipients will not have immediate access to a health home. Moreover, the ED likely will continue to play a vital role in a continuum of care, including those developed by IDSs. Pilots can serve as important learning opportunities on the comparative effectiveness of various models of emergency services treatment for persons with behavioral and other medical conditions.

We encourage support of demonstrations similar to the program at the UIC Medical Center, in other parts of the state and in other settings. Many of our academic medical centers and safety net hospitals have developed excellent psychiatric emergency services that could be enhanced under a waiver. Moreover, rural communities and communities outside the metropolitan Chicago area do not have a sufficient number of behavioral health services to meet demand. A crisis model recently developed in southern Illinois illustrates a partnership across providers, settings and disciplines to serve the unmet needs of a rural community. A waiver is the perfect opportunity to demonstrate the commitment of our state to such community solutions.

Among the LTSS services that are included in the waiver application are those of Specialized Mental Health Rehabilitation Facilities (SMHRFs), a new hybrid facility created exclusively in 2013 (pursuant to two court consent decrees), for the former IMD nursing facilities that are required to transition their residents to more community integrated settings. The waiver requests that SMHRFs be treated as "costs not otherwise matchable" for the five years of the waiver to "support crisis and acute rehabilitation services." We would encourage the state to also consider funding for alternative community-based systems of care, including community-based emergency and crisis services and supportive housing. Also, since SMHRFs are located in the metropolitan Chicago area, the waiver should take into consideration LTSS that can be offered in other areas of the state, particularly rural communities. **In particular, the waiver should put in place performance metrics for these LTSS initiatives so the outcomes can be measured and recipients of the funding are held accountable.**

Other Issues

IHA urges the State of Illinois to embrace the creation of children's hospital networks of care for children with medical complexities as part of the effort toward delivery system reform. We request that this policy initiative be specifically embraced in the proposed package of hospital/health system delivery system reforms, both as part of the Care Coordination Entity initiatives and as an explicit element of incentive-based pools.

We remain concerned that the application does not specifically recognize the needs of the 68 rural counties in Illinois. We recommend consideration of a Rural Health Innovations Program (RHIP). The RHIP would be specifically designed to accomplish the following: support the ability of rural providers to establish Patient-Centered Medical Homes (PCMH) with integrated behavioral health services; develop regional care coordination entities; and leverage technology and telemedicine for quality improvement and population health services. Many counties currently lack the necessary community support services to provide comprehensive care to Medicaid beneficiaries. A regional infrastructure for rural health providers would incentivize the development of comprehensive community-based programs to ensure access to quality health care services for Medicaid patients residing in rural areas of our state.

Thank you for the opportunity to comment on the draft application, and we look forward to learning more of the financial details so we can make a fully informed decision on the ability of the waiver achieve the stated goals. If you or your staff have any questions or comments, please contact Patrick Gallagher, Group Vice President, Health Delivery and Payment Systems at 630-276-5496 or pgallagher@ihastaff.org.

Sincerely,

Maryjane A. Wurth
President & CEO